MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Allied Health • Medical Transportation

January 2006 • Bulletin 363

Contents

Updated Crossover Billing Instructions for Outpatient Services

On October 24, 2005, new requirements for paper crossover claims for outpatient services were implemented to coincide with the automatic electronic crossover claims processed through United Government Services, LLC (UGS) or Mutual of Omaha. The major changes involve:

- Billing Medi-Cal with the same codes billed to Medicare
- Attaching a PC Print single claim detail version of the *Medicare National Standard Intermediary Remittance Advice* (Medicare RA) to all paper crossover claims for outpatient services
- Availability of electronic crossover billing
- New instructions for billing claims with more than 15 detail lines

Medi-Cal no longer allows the use of interim (local) codes for Medicare/Medi-Cal crossover billing. Providers should bill Medi-Cal using the same national codes displayed on the Medicare RA.

The PC Print single claim detail version of the Medicare RA is necessary for Medi-Cal claims processing, and claims received without the proper Medicare RA will be rejected. Some providers who did not previously elect to receive the electronic 835 remittance from Medicare are having difficulty complying with this requirement. In addition, if a provider's information is not updated to include the correct Medicare provider number on the Medi-Cal Provider Master File or the provider chooses to use a Medicare intermediary other than UGS or Mutual of Omaha, the claims can not cross over automatically and the provider must comply with the new paper billing instructions or bill Medi-Cal electronically.

To update the Medi-Cal Provider Master File with the appropriate Medicare provider number, submit a *Medi-Cal Supplemental Changes* form (DHS 6209). The form and instructions are available on the Medi-Cal Web site (from the home page, click "Provider Enrollment" and then "Application Forms"). The application must have an original signature and must include a letter on Medicare letterhead showing the provider's Medicare number. To expedite the process, the application may be sent to the California Department of Health Services (CDHS) Provider Enrollment Branch via overnight mail with a cover letter stating: "New Crossover Process. Please Expedite."

Providers having difficulty obtaining the proper Medicare RAs are urged to begin billing these crossover claims to Medi-Cal electronically. Contact the Telephone Service Center (TSC) at 1-800-541-5555 or visit the "CMC Submission Instructions" page on the Medi-Cal Web site (from the home page, click "CMC" under "Provider Resources") for information about electronic crossover billing.

Medi-Cal cannot process more than 15 lines per claim form for crossover claims for outpatient services. Therefore, crossover claims for outpatient services billed for more than 15 line items for Part B services billed to Part A Intermediaries require billing on two or more separate *UB-92 Claim Forms*. This process is called "split billing."

Please see **Crossover Billing**, *page 2*

Crossover Billing *(continued)*

Submit split-billed crossover claims according to the billing instructions in the *Medicare/Medi-Cal Crossover Claims: UB-92* section of the appropriate Part 2 manual. In addition, these claims require special crossover billing procedures:

- Each split-billed claim form must include the applicable remarks in the *Remarks* area.
- The Medicare RA must be attached to each split bill claim.
- The claim detail lines entered on the claim form must be in the same order as the RA.
- Bracket and label the RA details lines that correspond with each split bill claim.

Note: The amount entered on each split-billed claim is determined by the provider, but the sum of the amounts on each split-billed claim must equal the summary data on the Medicare RA.

For additional information about the requirements for paper crossover billing for outpatient services, including billing examples and instructions for billing more than 15 claim lines, please refer to the *Medicare/Medi-Cal Crossover Claims: UB-92* and *Medicare/Medi-Cal Crossover Claims: UB-92 Billing Examples* sections in the appropriate Part 2 manual. More detailed billing examples will be published in future *Medi-Cal Updates* and posted to the Medi-Cal Web site.

Updated information can be found on manual replacement pages medi cr ub 1 thru 4 and 7 thru 9 (Part 2) and medi cr ub ex 1, 2 and 5 thru 8 (Part 2).

Medi-Cal Crossover Claim Reminder

Providers are reminded that when Medicare makes an adjustment on a previously paid Medicare claim, the resulting automatic crossover Medicare adjustment does not get processed by Medi-Cal. When a provider receives a Medicare adjustment, the Medicare claim for the adjusted amount must be submitted in hard copy form. Prior to submitting the new claim for the adjusted amount, the provider must void the original Medicare payment, or the adjusted claim will be denied with Remittance Advice Details (RAD) code **010: This service is a duplicate of a previously paid claim**.

To receive correct reimbursement from Medi-Cal for a previously reimbursed Medicare crossover claim, providers may file either a *Claims Inquiry Form* (CIF) or an appeal.

For information about completing a CIF, refer to the *CIF Special Billing Instructions* section in the appropriate Part 2 manual. For information about appeals, refer to the *Appeal Form Completion* section in the appropriate Part 2 manual. *This information is reflected on manual replacement page cif sp 7 (Part 2).*

Procedure Code and Modifier(s) Combination on Claim and TAR Must Match

Effective for dates of service on or after March 1, 2006, the procedure code and modifier(s) combination on the claim submitted must match the procedure code and modifier(s) combination authorized on the *Treatment Authorization Request* (TAR). Failure to do so may result in denial of the claim.

Note: All current policies regarding the placement or order of modifiers on the claim and/or TAR remain the same.

837 v.4010A1 Electronic Claims with Attachments Now Available

Providers now have the ability to submit 837 v.4010A1 electronic claim submissions with attachments by either faxing the attachments or sending them electronically through an approved third-party vendor.

To utilize this new process, providers must be authorized to bill 837 v.4010A1 electronic claims. The fax process includes an *Attachment Control Form* (ACF), which is used as a coversheet for the supporting fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment. Providers submit the electronic claim, then fax the ACF and the attachments to Medi-Cal. Each ACF and corresponding attachments require a separate fax call. Each call to the fax server must include only one ACF as the first page followed by the attachment pages that correspond to that ACF. The phone number to fax attachments is 1-866-438-9377.

The electronic process involves approved third-party vendors that preprocess the attachments and send the images electronically on the provider's behalf. Medi-Cal links the faxed or electronic attachments to the appropriate electronic claim.

Providers have a maximum of 30 calendar days from the date of claim submission to submit the supporting faxed or electronic attachments. For further information regarding attachment submissions, please refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "HIPAA" link on the home page, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link and then the "Billing Instructions" link.

Instructions for Manual Replacement Pages — Part 2

January 2006

Medical Transportation Bulletin 363

Remove and replace:	cif sp 7/8
	hcfa sub 1/2 *
	medi cr ub 1 thru 4
Remove:	medi cr ub 7
Insert:	medi cr ub 7 thru 9 *(new)*
Remove and replace:	medi cr ub ex 1/2
Remove:	medi cr ub ex 5
Insert:	medi cr ub ex 5 thru 8 *(new)*

* Pages updated due to ongoing provider manual revisions.